PERSONALITY PATTERNS IN MALE VENEREAL DISEASE PATIENTS

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by

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CHAPTER I

INTRODUCTION

Man has been faced with the problem of controlling the spread of venereal disease for thousands of years. Biblical sources report that the prevention of gonorrhea was of concern as early as the time of Moses, when it was ordered that all the infected be killed to prevent a plague. From that time until the Columbian era the methods used to restrict the incidence of gonorrhea were the isolation or death of the infected.[1]

With the return of Columbus from America in 1493, syphilis was introduced to the then known world. His men, having been infected by the natives on the island of Haiti, carried the disease to Europe, where it spread rapidly, as any new disease among an unimmunized people does. The severity with which the disease plagued Europe served to awaken medicine from its sleep of the Middle-Ages. Crude methods of treatment were devised which often killed more

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[1]R. S. Morton, Venereal Diseases (London: Cox and Wyman Ltd., 1966), pp. 19-20.

people than they saved. Slight advances were made in the following four hundred years, but it was not until the beginning of the twentieth century that medicine made significant gains in the treatment of venereal disease.[1] Since 1950, new and safer methods of curing the patient have been introduced.[2] Suffering and death due to venereal disease have been virtually abolished. In producing a cure, medicine has decreased the number of possible transmitters in our population and has thus helped prevent the occurrence of further infection.

The speed with which these diseases are transmitted, however, keeps the number of infected persons in the population at a high and steadily increasing number, in spite of the medical treatment offered. Many of those who are cured become reinfected, and continue to spread the disease.

Though medicine has played, and continues to play, the major role in venereal disease control, the field of education has started to assume some responsibility in the

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[1]John H. Stokes, The Third Great Plague (Philadelphia: W. B. Saunders Company, 1920), pp. 11-13.

[2]Oliver E. Byrd, Health (Philadelphia: W. B. Saunders Company, 1961), p. 274.

area. The need for comprehensive venereal disease education was demonstrated in a study conducted by Schofield in 1965. He discovered that over one-half of the 1,873 teen-agers he interviewed did not know the symptoms of any of the venereal diseases. Further questioning revealed that their major source of information was their friends, not competent authorities.[1] This lack of knowledge could be greatly reduced through comprehensive venereal disease education in our schools and public health services. However, insufficient finances and the lack of popular support, have prevented the development of programs in all but a few states.[2] At the present time, information regarding the effectiveness of formal education in reducing the incidence of venereal disease is not available, but these programs do hold great promise.

The role of psychological variables in venereal disease transmission has been minimally investigated. A

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[1]Michael Schofield, The Sexual Behavior of Young People (Boston: Little, Brown and Company, 1965), pp. 117-118.

[2]Today's V. D. Control Problem. Prepared and Edited by the Staff of the American Health Association (March, 1964), p. 29.

small body of literature pertaining to the mental and personality characteristics of those prone to venereal disease is available. An overview of some of these works will be given to point out the need for the present study.

Early psychological investigation was concerned primarily with reporting the emotional states accompanying venereal disease. Austin Cheever, for example, observed that those who had been infected with syphilis were often afraid to marry and have children. Some women who were pregnant at the time the disease was diagnosed sought abortions for fear that their children would be malformed. Married patients feared divorce from a non-understanding mate. Children who had been congenitally infected, and were not told of the disease in an accepting way, often developed a hate for and hostility toward their parents.[1]

Wessel and Pinck observed that soldiers who contracted venereal disease during World War II became anxious when ordered to return home. The anxiety was usually attributable to the fear that relatives, or other significant

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[1]Austin Cheever, "Emotional Disturbances Accompanying Syphilis," The American Journal of Nursing, XXX (May, 1930), 557-562.

persons, might discover that he had been infected. The assurance of confidentiality easily dispelled this worry. In a few cases, however, this anxiety was so severe that the patient imagined himself reinfected, in spite of medical reports showing the contrary. The authors described the condition as ". . .deepseated, progressive, [and] often obsessive-compulsive in nature. . . . Psychiatric treatment inevitably dominate [d] the therapeutic course. Frequently, hospitalization [was] necessary."[1] (Brackets are the current author's.) Studies such as these are of passing interest, but their value to a scientific study of personality and venereal disease is suspect. The lack of scientific methodology makes it impossible to verify the results, and thus one is totally dependent on the views expressed by various writers.

A more objective study on the psychiatric characteristics of soldiers who reported for venereal disease treatment was reported by Brody in 1947. Instead of relying completely on his observations, he used a standard interview to assess the personalities of the subjects. The infected

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[1]Morris A. Wessel and Bernard D. Pinck, "Venereal Disease Anxiety," Mental Hygiene, XXXI (October, 1947), 636-646.

men were compared with a group of psychoneurotics and a group of normals. The findings suggest that men with venereal disease were more unrestrained, readier to take chances, more easily influenced, and more lascivious than control groups. Sexual intercourse played a more prominent role in the infected man's life, and although he selected his women less often than other groups, he was selected more often by women because of his libidinous ways.[1]

Truly objective work in this area is relatively hard to find. In 1956, Scarborough published one such study on the mental characteristics of the venereal disease patient. He administered the Wechsler-Bellevue Adult Scale Form I to two groups of infected subjects. The first group contained twenty-four Negro subjects and the second, sixteen white subjects. All the subjects were residents of the state of Georgia. In comparing their results with control groups (United States' Veterans matched for age, education, job level, and urban-rural residence), he discovered that there were no major differences with regard to intelligence as

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[1]Morris W. Brody, "Psychiatric Characteristics of Patients with Venereal Disease," Archives of Neurology and Psychiatry, LVII (January, 1947), 125-127.

assessed by the complete scale.[1] Although the study had a small sample, the results tentatively indicate that intelligence is not a major variable in venereal disease transmission.

No objective study has been reported in the literature concerning the relationship between personality variables and venereal disease incidence. The present study will investigate this area.

The identification of personality variables significant to the venereal disease group would be of value both scientifically and practically. Isolating such personality variables would increase man's knowledge of himself. More important, however, are the implications for treatment of the diseased. If significant personality variables can be found in infected subjects, appropriate methods of psychological as well as medical treatment of such persons would decrease the number of persons prone to reinfection, and in so doing, help control the spread of venereal disease.

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[1]B. B. Scarborough, "Some Mental Characteristics of Southern Colored and White Venereal Disease Patients as Measured by the Wechsler-Bellevue Test," Journal of Social Psychology, XLIII (May, 1956), 313-321.

CHAPTER II

INVESTIGATION

I. HYPOTHESES

In determining the psychological characteristics peculiar to those infected with venereal disease, several research hypotheses were tested. Before these are presented, however, two terms must be defined. Non-repeaters were those persons diagnosed as having venereal disease, who stated that they had not previously been infected. Repeaters were those who stated that they had been infected with venereal disease at least once prior to the current infection.

The six research hypotheses tested are that:

1. There is a significant difference in personality between those persons who report to the Public Health Service for venereal disease treatment and those who have no history of the disease.
2. Repeaters differ significantly in personality from members of a general population control group.
3. There is a significant personality difference between

repeaters and non-repeaters who report to the Public Health Service.

4. There is a significant pattern of scores on the Minnesota Multiphasic Personality Inventory for venereal disease patients, if no single scale can differentiate them from a control group.
5. There is a relationship between the Minnesota Multiphasic Personality Inventory scores and information obtained from a questionnaire.
6. There is a significant difference in descriptive data from the questionnaire between repeaters and non-repeaters.

II. INSTRUMENTS

Two instruments were used in evaluating each infected subject for the present study. Facets of personality were assessed by the Minnesota Multiphasic Personality Inventory (MMPI), and a brief questionnaire was used to collect information on selected areas of the subject's history.

Minnesota Multiphasic Personality Inventory. The MMPI is considered to be one of the best objective measures of personality currently available. It consists of 566

easily readable statements which are to be answered "true", "false", or "cannot say" as they apply to the testee.

> the. . .items range widely in content, covering such areas as: health, psychosomatic symptoms, neurological disorders, and motor disturbances; sexual, religious, political, and social attitudes; educational, occupational, family, and marital questions; and many well-known neurotic and psychotic behavior manifestations, such as obsessive and compulsive states, delusions, hallucinations, ideas of reference, phobias, sadistic and masochistic trends, and the like.[1]

Over two hundred personality scales have been developed from this array of items. However, only ten of these (usually called the clinical scales) are commonly used. They are:

1. Hypochondriasis (Hs) Exaggerated anxiety about one's health and pessimistic interpretations and exaggerations of minor symptoms
2. Depression (D) Feelings of pessimism, worthlessness, hopelessness
3. Hysteria (Hy) Various ailments such as headaches and paralysis which have no physical basis
4. Psychopathic deviation (Pd) Antisocial and amoral conduct
5. Masculinity-femininity (Mf) Measure of masculine and feminine interests; especially a measure of feminine values and emotional expression in men
6. Paranoia (Pa) Extreme suspiciousness of other people's motives, frequently resulting in elaborate beliefs that certain people are plotting against one

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[1]Anne Anastasi, Psychological Testing (New York: The Macmillan Company, 1961), pp. 498-499.

7. Psychasthenia (Pt) Irrational thoughts that recur and/or strong compulsions to repeat seemingly meaningless acts
8. Schizophrenia (Sc) Withdrawal into a private world of one's own, often accompanied by hallucinations and bizarre behavior
9. Hypomania (Ma) Mild elation and excitement without any clear reason
10. Social introversion (Si) Avoidance of other people and removal of oneself from social contacts[1]

Four validity scales, or scores, have also been constructed for this inventory. They function as

> . . .checks on carelessness, misunderstanding, malingering, and the operation of special response sets and test taking attitudes. The validity scores include:
>
> 1. The Question Score (?): the **total** number of items put into the cannot say category.
> 2. The Lie Score (L): based upon a group of items that make the subject appear in a favorable light, but are unlikely to be truthfully answered in the favorable direction.
> 3. The Validity Score (F): determined from a set of items very infrequently answered in the scored direction by the standardization group. Although representing undesirable behavior, these items do not cohere in any pattern of abnormality. Hence it is unlikely that any one subject actually shows all or most of these symptoms. A high F score may indicate scoring errors, carelessness in responding, gross eccentricity, or deliberate malingering.
> 4. The Correction Score (K): utilizing still another combination of specially chosen items, this score provides a measure of test-taking attitude, related

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[1]Clifford T. Morgan and Richard A. King, Introduction to Psychology (St. Louis: McGraw-Hill Book Company, 1966), p. 451.

> to both L and F, but believed to be more subtle. A high K score may indicate defensiveness or an attempt to "fake good." A low K score may represent excessive frankness and self-criticism or a deliberate attempt to "fake bad."[1]

The ?, L, and F scales are used in evaluating the complete inventory. An invalid test is suspected if the score on any one of these three exceeds a certain limit. The K score functions as a "suppressor variable", and is used to obtain adjusted totals on several of the scales.

An individual's performance is determined through the use of standard procedures. A raw score is determined for each scale, and is then transferred to a profile from which equivalent T scores can be read. If the T score on any one of the clinical scales is seventy or greater (two or more standard deviations from the mean) a pathological deviation is suspected. In general, there is a direct relation between the heighth of the scale above seventy and the severity of the disturbance. However, the peaks and slopes of the profile must also be taken into account in interpreting the results.

Questionnaire. The questionnaire, developed by the

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[1]Anastasi, op. cit., pp. 499-500.

Polk County Health Center, consists of twenty-one items. Information concerning age, sex, race, marital status, educational and work experience, and church preference and attendance was gathered by the instrument. Although data on the subject's length of residence in the Des Moines community were collected, they were not used in the present study. Item twenty-one (Have you ever had Venereal Disease before?) was used to differentiate repeaters from non-repeaters. A copy of the complete questionnaire may be found in the Appendix.

III. SUBJECTS

All males reporting to the Polk County Health Center who would co-operate with the study were used as subjects. Those males who would not participate were excluded. Females were not included because of the low frequency with which they report to the public service for treatment.

In Table I, the data on the age and education of the subjects is given for the total venereal disease group, the repeaters, and the non-repeaters.

IV. METHOD OF PROCEDURE

Individuals seeking treatment for venereal disease

TABLE I

AGE AND EDUCATION DATA FOR THE THREE EXPERIMENTAL GROUPS

	Total	Repeaters	Non-Repeaters
Age in Years			
Mean	22.7	23.7	21.8
Median	21.7	23.4	21.2
Standard Deviation	3.9	2.3	4.2
Number of Subjects	62.0	28.0	34.0
School Grades Completed			
Mean	11.7	11.1	12.2
Median	12.1	11.5	12.5

at the health center were first given the "smear test" to determine if they were, in fact, infected. If the results were positive (indicating venereal disease) an injection of penicillin sufficient to combat the disease was given.

The MMPI and the questionnaire were administered immediately after the person had been treated. After the subject completed the MMPI, it was scored and profiled according to standard procedures. The data gathered from all the subjects were then analyzed through the use of the mean profile comparisons and the *t* test of statistical significance. The descriptive data from the questionnaire were compared with the MMPI results. Comparisons were also made between the repeaters and non-repeaters on the basis of the descriptive data.

CHAPTER III

FINDINGS

I. MMPI ANALYSIS

Analysis of both single scales and patterns (a configuration of scales) was carried out on the MMPI. The profiles were separated into three groups for this section of the examination. The first group consisted of all the subjects, the second of the non-repeaters, and the third of the repeaters. A mean T score profile was constructed for each of these groups. The profiles may be found on the following pages. Comparisons were made between each of the groups and the standardization sample for the MMPI. The repeaters and non-repeaters were also contrasted.

All subjects were used in the computation of the validity scales for the mean profiles. On the clinical scales, those subjects who had a validity score exceeding eighty were excluded from the clinical analysis, because T scores of eighty or more on the validity scales were regarded as invalid.

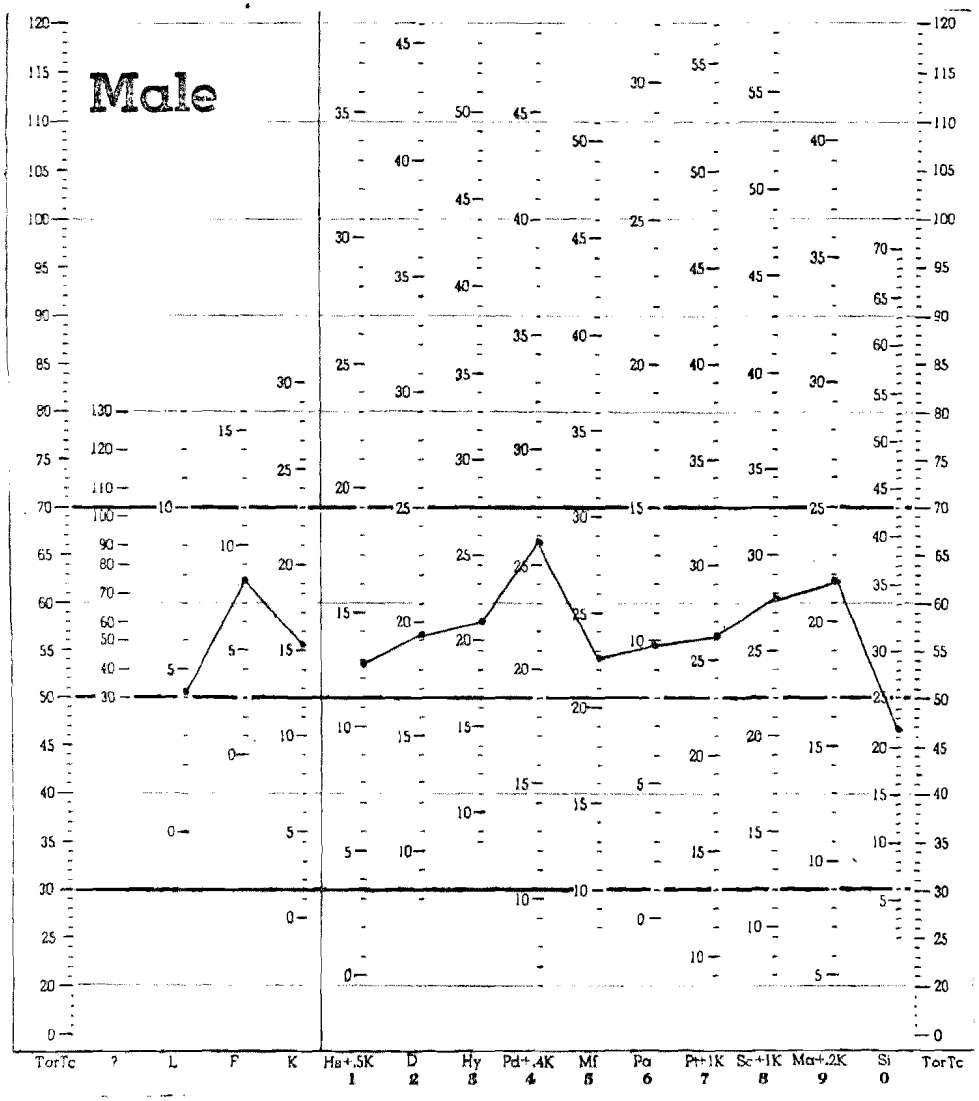

Figure 1. Mean profile - total group.

L - F - K = N = 73
Clinical scales = N = 62

L	50.38
F	62.29
K	55.44
Hs	53.45
D	56.12
Hy	57.82
Pd	66.25
Mf	54.38
Pa	55.16
Pt	56.69
Sc	60.32
Ma	62.50
Si	46.91

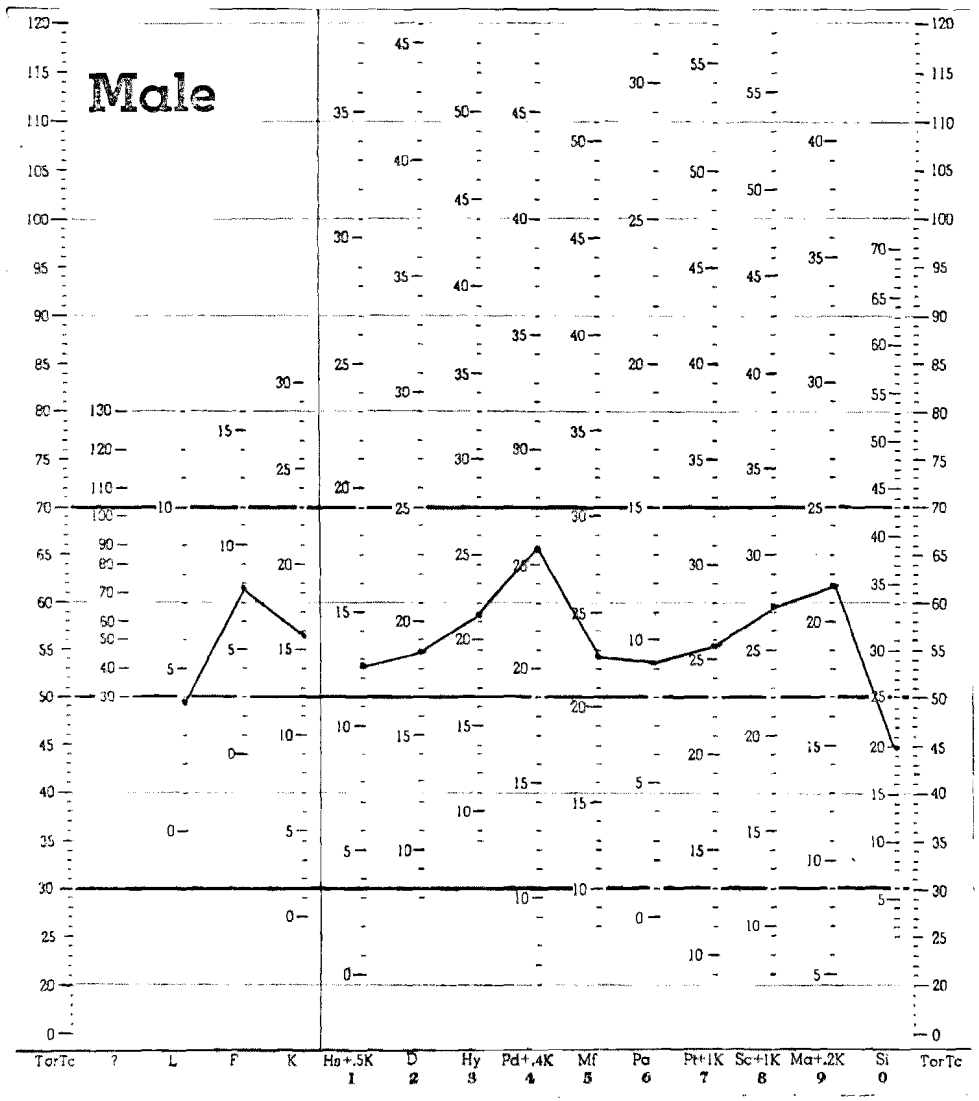

Figure 2. Mean profile - non-repeater group.

L - F - K = N = 41
Clinical scales = N = 34

L	49.83
F	61.85
K	56.71
Hs	53.26
D	54.74
Hy	58.35
Pd	65.15
Mf	54.32
Pa	53.38
Pt	55.59
Sc	59.85
Ma	61.71
Si	45.00

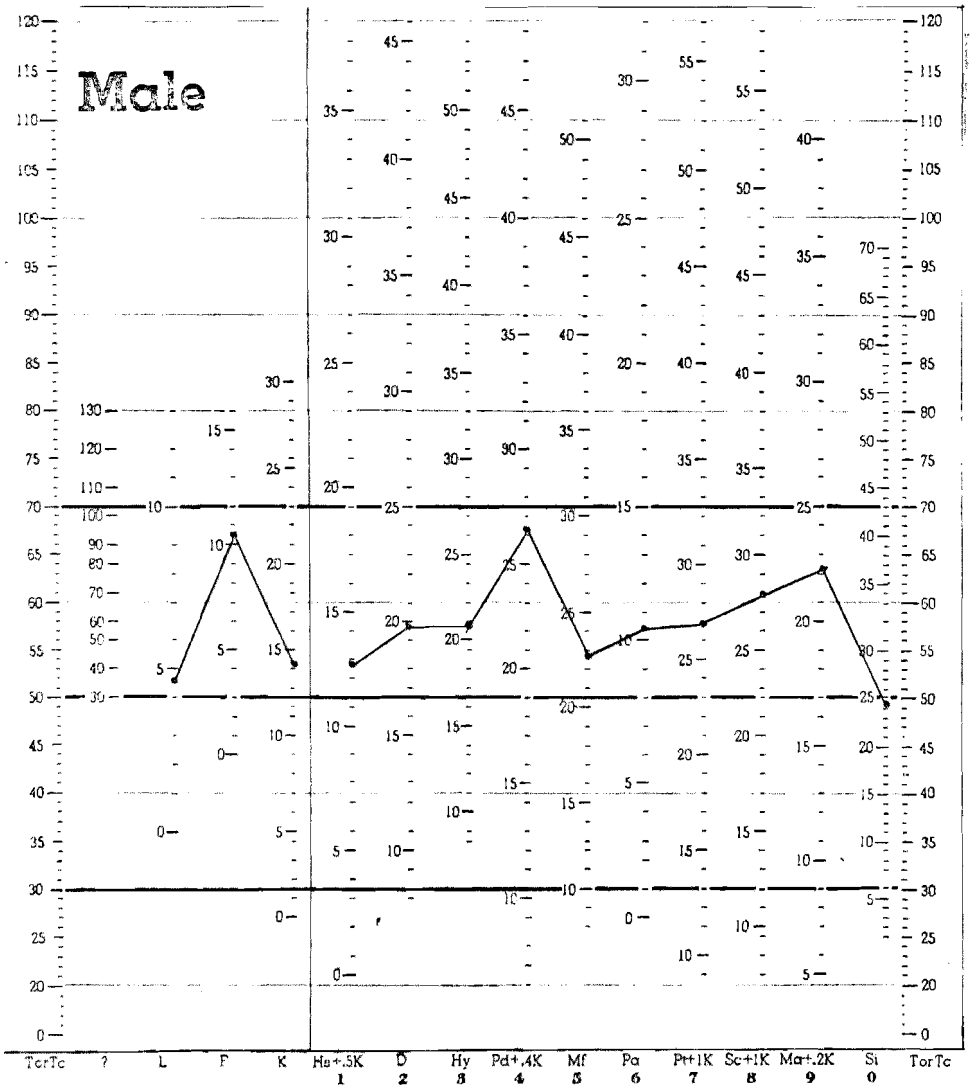

Figure 3. Mean profile - repeater group.

L - F - K = N = 32
Clinical scales = N = 28

L	51.09
F	66.84
K	53.81
Hs	53.68
D	57.82
Hy	57.18
Pd	67.61
Mf	54.46
Pa	57.32
Pt	58.04
Sc	60.89
Ma	63.46
Si	49.18

Single scale analysis. The profile of each group is elevated above the normal population on all scales except Social Introversion. However, for the present study only those scales falling one or more standard deviations from the mean (a T score of sixty or greater) will be considered.

Both the total group and the repeater profiles show the same four scales above sixty. These are the F, Psychopathic Deviate, Schizophrenia and Hypomania scales. The profile of the non-repeaters differs only in that the Schizophrenia scale does not exceed a T score of sixty.

In the MMPI Handbook, Dahlstrom and Welsh discuss some of the behaviors exhibited by persons with elevations on the various scales. Their findings concerning the scales examined by this investigation will be reviewed.

The F scale is one of the validity scales on the MMPI. It is made up of items that were rarely endorsed by the standardization group. Some items deal with peculiar thoughts and beliefs, denial of social ties, and frank expressions of psychiatric symptoms. Others deal with apathy, lack of interests, control over impulses, along with several additional areas.[1] Elevation on this scale

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[1]W. Grant Dahlstrom and George Schlager Welsh. An

may be interpreted in two ways. It may indicate that the subject is trying to fake bad, or it may suggest a person who is disturbed and truthfully sees himself as undesirable. The best way to distinguish between these groups is through contact with the patient.

The Psychopathic Deviate scale contains items relating to ". . .family discord, authority problems, and social imperturbability and alienation."[1] The major characteristics of those scoring high on this scale are

> . . .a repeated and flagrant disregard for social customs and mores, an inability to profit from punishing experiences as shown in repeated difficulties of the same kind, and an emotional shallowness in relation to others, particularly in sexual and affectional display.[2]

The items on the Schizophrenia scale deal with the

> . . .bizarre mentation, the social alienation, the peculiarities of perception, and the feelings of persecution included in the classic description of schizophrenia.

Items concerning familial relationships, lack of interests, difficulties in concentration, impulse control and sexual

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MMPI Handbook (Minneapolis: The University of Minnesota Press, 1960), pp. 49-50.

[1]Ibid., p. 62.

[2]Ibid., p. 60.

matters are included.[1] The one word best describing the person who scores high on this scale is immature. He has problems handling aggression, has unresolved internal struggles, and is generally dissatisfied with himself.[2]

The Hypomania scale consists of items dealing with ". . .the grandiosity, the excitement, and the activity level" typical of the hypomanic. Also present are items concerning family relations, moral attitudes, and physical and body matters. Persons elevated on this scale are over-active, emotionally excitable, usually sociable, energetic and in a state of euphoria.[3]

The mean profiles of the non-repeaters and repeaters were compared to determine if any single scale could differentiate them. The t test of statistical significance was used to contrast these groups on each scale.[4] A confidence level of .05 was chosen. All seventy-three cases were used in analyzing the validity scales, but only the sixty-two

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[1] Ibid., pp. 72-74.

[2] Ibid., p. 201.

[3] Ibid., pp. 74-76.

[4] Murray R. Spiegel. Theory and Problems of Statistics (New York: Schaum Publishing Company, 1961), pp. 194-195.

having all validity scores below eighty were used to evaluate the clinical scale differences. In this manner a check was kept on the validity of the clinical scales without sacrificing data from the validity scales.

In Table II, the mean of each group and the value of *t* is given. One scale, Social Introversion, was statistically significant. The non-repeaters scored higher on this scale than the repeaters. The difference between the means of the two groups on this scale and the mean of the normal population was not sufficient to suggest an alternate personality description. However, the scale does have the ability to differentiate these two groups from an unspecified venereal disease population.

These characteristics are typical of persons with high scores on the four scales presently under consideration.

The Psychopathic Deviate scale plays an important part in the description of the subjects, especially when examined with other scales in pattern analysis. Personality descriptions have been formulated for groups of scales elevated in a certain sequence, called patterns. Some of the patterns found in studying the venereal disease profiles will be discussed.

TABLE II

MEAN AND *t* VALUES FOR THE
NON-REPEATER AND REPEATER GROUPS

Scale	Mean Non-Repeaters	Mean Repeaters	*t*
L	49.83	51.09	0.75
F	61.85	66.84	0.42
K	56.71	53.81	0.41
Hs	53.26	53.68	0.20
D	54.74	57.82	1.06
Hy	58.35	57.18	0.61
Pd	65.15	67.61	0.85
Mf	54.32	54.46	0.03
Pa	53.38	57.32	1.72
Pt	55.59	58.04	0.86
Sc	59.85	60.89	0.52
Ma	61.71	63.46	0.62
Si	45.00	49.18	2.46*

*Significant at .05 level.

Pattern analysis. The relative elevation method of pattern analysis was used to determine the pattern high points for the mean profiles. In this method the two scales with the highest T scores are used as the basis for personality description. Although the validity scales may exceed the clinical scales, they are not considered in determining the high points for pattern analysis.

The three mean profiles show the same high point pattern, the Psychopathic Deviate scale (number 4) and the Hypomania scale (number 9). Dahlstrom and Welsh discuss this pattern. They state that:

> Persons with this profile pattern show clear manifestations of psychopathic behavior, the hypomania seemingly energizing or activating the pattern related to scale 4. That is, these people tend to be overactive and impulsive, irresponsible and untrustworthy, shallow and superficial in their relationships. They are characterized by easy morals, readily circumvented consciences, and fluctuating ethical values. To satisfy their own desires and ambitions, they may expend great amounts of energy and effort, but they find it difficult to stick to duties and responsibilities imposed by others. In superficial contacts and social situations they create favorable impressions because of their freedom from inhibiting anxieties and insecurities. They are lively, conversational, fluent, and forthright; they enter wholeheartedly into games, outings, and parties, without being self-conscious or diffident. However, their lack of judgment and control may lead them to excesses of drinking, merrymaking, or teasing. They may be prone to

> continue activities so long that they exceed the proprieties, neglect other obligations, or alienate others.[1]

In Table III, all of the two-point patterns found in this study are listed with the frequency and percentage of their occurrence. The percentage of each group for which a scale is capable of accounting when it is in either position in a two-point pattern is presented in Table IV. Scale 4 in conjunction with other scales (4, ? or ?, 4) is able to correctly identify 54.88% of the total sample. Patterns containing scale 9 account for 45.20% of the total. When the 4, 9 and 9, 4 pattern percentages are combined, 17.74% of the total, 23.53% of the non-repeaters and 10.71% of the repeaters are accounted for.

II. THE MMPI AND DESCRIPTIVE DATA

Data concerning marital status, education, church attendance, and work history were collected from the questionnaire and separated into the repeater, non-repeater and total groups.

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[1] Ibid., p. 189.

TABLE III

FREQUENCY AND PERCENTAGE OF TWO-POINT PATTERNS

P	N	%	R	%	T	%
12	0	0	1	3.6	1	1.6
21	1	2.6	0	0	1	1.6
23	1	2.6	1	3.6	2	3.8
24	1	2.6	0	0	1	1.6
27	1	2.6	0	0	1	1.6
34	2	5.8	1	3.6	3	4.8
35	1	2.6	0	0	1	1.6
36	1	2.6	0	0	1	1.6
41	1	2.6	3	10.7	4	6.5
42	2	5.8	0	0	2	3.8
43	2	5.8	3	10.7	5	8.1
45	1	2.6	1	3.6	2	3.8
46	0	0	2	7.1	2	3.8
48	3	8.8	0	0	3	4.8
49	2	5.8	1	3.6	3	4.8
58	0	0	1	3.6	1	1.6
69	0	0	1	3.6	1	1.6
72	0	0	1	3.6	1	1.6
84	0	0	1	3.6	1	1.6
85	1	2.6	0	0	1	1.6
86	0	0	1	3.6	1	1.6

TABLE III (continued)

P	N	%	R	%	T	%
89	2	5.8	3	10.7	5	8.1
91	0	0	1	3.6	1	1.6
93	2	5.8	2	7.1	4	6.5
94	6	17.6	2	7.1	8	13.0
95	0	0	1	3.6	1	1.6
96	1	2.6	0	0	1	1.6
98	3	8.8	1	3.6	4	6.5

The MMPI scales are listed by number instead of by name. The numbers corresponding to the names are:

1. Hypochondriasis
2. Depression
3. Hysteria
4. Psychopathic Deviate
5. Masculinity-feminity
6. Paranoia
7. Psychasthenia
8. Schizophrenia
9. Hypomania
0. Social Introversion

TABLE III (continued)

The symbols employed in the Table are:

P= the two-point code. For example 9, 4 means the Hypomania and Psychopathic Deviate scales in that order.

N= Non-repeaters.

R= Repeaters.

T= Total group, repeaters plus non-repeaters.

TABLE IV

PERCENTAGE OF CASES FOR WHICH EACH SCALE IN EITHER POSITION IN A TWO-POINT PATTERN CAN ACCOUNT*

P	N%	R%	T%
1	5.9	17.9	9.7
2	17.6	10.7	14.5
3	26.5	25.0	25.8
4	58.8	50.0	54.8
5	8.8	10.7	9.7
6	5.9	14.3	9.7
7	2.9	3.6	3.2
8	26.4	25.0	25.8
9	47.1	42.9	45.2
0	0	0	0

*In this Table "P" denotes the scale under consideration. The frequencies used to calculate the percentages were determined by summing the cases in which the selected scale was in the first position of the pattern with the cases in which the scale was in the second position. Division by the total number of cases and multiplication by one hundred converted this frequency into a percentage.

The MMPI Handbook treats only one of these areas, work record, in its discussion of the four scales and one pattern previously investigated. The number of jobs held by the average subject over a two year period was 2.7 for the repeaters, 2.3 for the non-repeaters, and 2.5 for the total group. Guthrie noted that persons high on the Psychopathic Deviate scale showed poor work records, especially if the 4, 9 pattern was present.[1] Venereal disease subjects showed both the elevated Psychopathic Deviate scale and the poor work record. Thus a connection between the MMPI and the descriptive data was established.

III. ANALYSIS OF DESCRIPTIVE DATA

The *t* test was used to compare the repeater and the non-repeater on the four categories of descriptive data used in this study. The .05 level of confidence was used for determining statistical significance. The only area in which significance was reached was education. The raw data on education presented in Table V reveals that only one of the twenty-eight repeaters had any formal education

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[1] Ibid., p. 189.

TABLE V

DESCRIPTIVE DATA FROM THE QUESTIONNAIRE

	Repeaters	%	Non-repeaters	%	Total	%
Marital Status						
Single	20	71.4	27	79.4	47	75.8
Married	3	10.7	4	11.8	7	11.3
Divorced	5	17.9	3	8.8	8	12.9
Highest Grade Completed						
8	1	3.6	2	6.1	3	4.9
9	4	14.3	3	9.1	7	11.5
10	3	10.7	3	9.1	6	9.8
11	6	21.4	2	6.1	8	13.1
12	13	46.4	7	21.2	20	32.8
13	0	0	5	15.1	5	8.2
14	1	3.6	6	18.2	7	11.5
15	0	0	4	12.1	4	6.6
16	0	0	1	3.0	1	1.6
Church Attendance						
Every Week	1	4.0	4	14.8	5	9.6
Once a Month	4	16.0	7	25.9	11	21.2
Seldom	14	56.0	10	37.1	24	46.1
Never	6	24.0	6	22.2	12	23.1
Number of Jobs in Last Two Years						
1	7	25.0	10	35.7	17	30.4
2	8	28.5	7	25.0	15	26.8
3	6	21.4	5	17.9	11	19.7
4	5	17.9	3	10.7	8	16.1
5	1	3.6	3	10.7	4	7.1
6	0	0	0	0	0	0
7	1	3.6	0	0	1	1.8

The number of cases in each category differs because the data on some subjects was incomplete.

beyond high school. Sixteen of the thirty-three non-repeaters, however, had gone past high school. This data suggests that education may be related to the frequency with which a person contracts venereal disease.

CHAPTER IV

DISCUSSION

The relationship between personality and venereal disease was examined in this study. The investigation was designed to determine if personality variables were present in venereal disease patients which could differentiate them from the normal population. Non-repeaters and repeaters were also contrasted to determine if personality plays a role in the frequency with which a person becomes infected.

The personality of each subject was assessed by the MMPI and a questionnaire was used to collect descriptive data. Four scales were found to be capable of separating the venereal disease group from the normal population. These were the F, Psychopathic Deviate (number 4), Schizophrenia (number 8), and Hypomania (number 9) scales. Pattern analysis revealed that the 4, 9 and 9, 4 patterns, when combined, accounted for the greatest percentage of venereal disease subjects.

Although these patterns are capable of discriminating the venereal disease group from the normal population, they

would be of little value when applied to an unspecified group of subjects. Dahlstrom and Welsh report that these same patterns are high in persons prone to suicide, alcoholism, delinquency, and criminality.[1] Thus no single pattern is capable of distinguishing venereal disease subjects from all other groups.

One scale, Social Introversion, was statistically significant in differentiating the repeaters from the non-repeaters. However, the elevation of neither group on this scale was sufficiently high to warrant a personality description different from that of the normal population.

The descriptive data was equally unproductive in separating the repeaters and non-repeaters. The only statistically significant difference found was in the area of education. However, the only inference that can be drawn from the data is that non-repeaters tend to complete high school and go on to college more often than repeaters.

The results of the investigation indicate that venereal disease subjects may be ". . .characterized by easy morals, readily circumvented consciences, and fluctuating

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[1]Dahlstrom and Welsh, op. cit., pp. 322-329.

ethical values." They may also be shallow in personal relationships, overactive, and impulsive.[1]

Studies such as Brody's (see Chapter I) report similar findings. However, it was not until the present study that any objective measures of personality were used to investigate this group of people.

In spite of the data from both the observational and objective studies, little has been done in the area of treatment with regard to personality. No more than the required medical treatment is being given at public facilities. These health services may in fact be increasing the incidence of venereal disease. The shot of penicillin is given free of charge and no penalty is imposed on those persons who report frequently.

It seems that a program of behavior modification could be of value in extinguishing those behaviors which lead to frequent venereal disease infection. The treatment of each patient could be made contingent upon attendance at lectures and films concerning these diseases.

Such a program would both inform and punish the

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[1] Ibid., p. 192.

patient. Those seeking treatment for the first time would profit from the educational aspects of this program. The patient would be made aware of the venereal diseases, and the dangers associated with them. This knowledge would help reduce the probability of his becoming reinfected. The repeaters would find these sessions more boring each time they had to sit through them. The writer feels that they would be careful not to become reinfected because of this punishment.

The value of such a program in reducing the incidence of venereal disease should be tested.

CHAPTER V

SUMMARY

No objective study on the personality variables of the venereal disease patient could be found in the literature. The present study was designed to investigate this area.

The MMPI and a questionnaire were administered to venereal disease patients reporting to the Polk County Health Center in Des Moines, Iowa for treatment. The data on male patients collected from these instruments were analyzed through the use of mean profile comparisons and the *t* test of statistical significance to determine if differences between the venereal disease group and the normal population could be discovered. Comparisons were also made between the non-repeating and repeating venereal disease subjects for personality pattern differences.

Personality pattern differences were found on four scales of the MMPI. They were the F, Psychopathic Deviate, Schizophrenia, and Hypomania scales. It was found that the combination of the Psychopathic Deviate and Hypomania scales

in a pattern could account for the greatest majority of the venereal disease patients. This pattern, however, was not able to discriminate the venereal disease group from other deviant groups, such as delinquents and alcoholics.

The repeaters and non-repeaters were significantly different on the Psychasthenia scale, but neither was sufficiently elevated above the normals to warrant an alternate personality description.

The descriptive data showed a difference between the repeaters and non-repeaters with regard to educational attainment; however, the only inference that could be made was that the non-repeaters tend to complete more years of schooling.

The need for psychological as well as medical treatment in health centers was discussed.

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C. OTHERS

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APPENDIX

QUESTIONNAIRE

1. Age_____

2. Sex_____

3. Race_____

4. Marital Status: Single_____ Married_____ Divorced_____

5. Married: How many times_____

6. Have you lived in Des Moines all your life:
   Yes_____ No_____

7. How long have you lived in Des Moines:
   Months_____ Years_____

8. Name of hometown_____ County_____ State_____

9. Highest grade completed in school_____

10. Name of grade school_____ City_____

11. Name of high school_____ City_____

12. Name of college or technical school_____ City_____

13. Last year you attended any school_____

14. What church do you attend_____

15. How often do you attend: Every week_____ Seldom_____
    Once a month_____ Never_____

16. Have you a trade or profession: Yes_____ No_____

17. What is your occupation_____

18. Type of business_____

19. Length of time at present job: Months_____ Years_____

20. How many different jobs have you had in the past two years_____

21. Have you ever had Venereal Disease before:
    Yes_____ No_____